Exhibit 11

1201 Flushing Rd
Flint, MI 48504

Mohammed Syed, M.D.

810-235-8532
Fax: 810-235-8023

Patient:
DOB:
DOS: 05/10/2010

CC: Patient here for F/U on MVA.

HPI: Patient here for F/U on MVA.She stated she was a restrained driver and her car was hit from behind and she felt a neck jerk,police arrived on scene Complains of back pain since the accident. no head injury or loss of consciousness.
Pain is in the lower back worse with movement or bending. No radiation of pain to the lower ext. No tingling or numbness, no weakness. No problem controlling bladder or stools.No nausea/vomiting and abdominal pain, no skin rash, no cough or fever.
Patient also complains of pain is in the thoracic spine area,worse with movement or bending. no radiation of pain to the lower ext. no tingling or numbness, no weakness.no problem controlling bladder or stools.No nausea/vomiting and abdominal pain, no skin rash, no cough or fever.

Medications: None
Allergies: PCN

PMH: GERD
PSH: C-section 1989
SHx: No Drugs; No Smoking; No drinking
PFH: CVA; Diabetes mellitus: Mother, father; HTN: Mother; Mother
ROS:
General: no fever, or chills. no recent weight gain or weight loss.
Head: No headaches, no swelling, no injuries.
HEENT: No sore throat, no earache, no nasal congestion, no sinus pain.
Chest: No cough, no chest pain, no SOB.
Heart: No Chest pain, no palpitations, no fainting or weakness.
Abdomen: No abdominal pain, no nausea or vomiting, no diarrhea, no constipation and no blood in the stools.
Ext: No edema, no calf pain.
Skin: no new skin rash
Exam:
Vitals: WEIGHT 148.2 |BP 130/78 |RESP 20 |PULSE 88 |NOTES DBC
General: Patient is alert, awake, and in no distress.
HEENT: Throat was normal, TMs normal, no lymphadenopathy, no thick nasal discharge.
Chest: Clear to auscultation, no crackles, wheezing, or rales were noted.
Heart: Regular rate and rhythm, no murmurs or extra sounds noted. No JVD
Abdomen: No tenderness, no masses, no organomegalies, no rebound tenderness, bowel sounds were normal.
Ext: No edema noted, positive pedal pulse. No skin changes, or ulcers noted.
BACK: Muscle spasms noted along spine.
Back: Is tender to touch in the lumbar area. Some spasm noted too. ROM of the back is somewhat limited due to pain. SLR negative, no sensory, motor or vascular deficit in the lower ext. No vertebral tenderness.

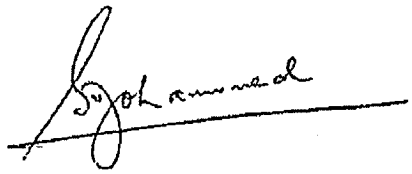
DOS:05/10/2010

Scripts: Ultram, 50mg, take one BID, #60, 0 Refills ;Flexeril, 10, take one @ bedtime, #30, 0 Refills ;

Orders: Refer to 1 st rehab–Lumbar and thorasic back pain due to MVA, follow up 1 week;

Assessment: Back strain secondary to MVA
1) Acute Lumbar Strain.
2) Acute Thoracic Strain.

Plan:
1) Pain meds, muscle relaxants, back exercises, physical and occupational therapy.
2) To ER if any problems with severe pain, problem controlling bladder or stools.
3) Pain meds, muscle relaxants, back exercises, consider PT or a chirpractor if not better in few days.
4) Safety education discussed with patient.
I explained to the patient the side effects, complications and what to expect from the medicines.
Patient councelled regarding compliance to treatment and regular follow ups.



Mohammed Syed, M.D.
Digitally Signed
Charted: 05/10/2010

1201 Flushing Rd
Flint, MI 48504

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810-235-8532
Fax: 810-235-8023

Patient:
DOB:
DOS: 05/17/2010

CC: Patient here for F/U on MVA.

HPI: Patient here for F/U on MVA. Complains of back pain since accident. Patient denies numbness and tingling in extremities.patient is under physical therapy.
ROS:
General: no fever, or chills. no recent weight gain or weight loss.
HEENT: No sore throat, no earache, no nasal congestion, no sinus pain.
Chest: No cough, no chest pain, no SOB.
Heart: No Chest pain, no palpitations, no fainting or weakness.
Abdomen: No abdominal pain, no nausea or vomiting, no diarrhea, no constipation and no blood in the stools.
Ext: No edema, no calf pain.
Medications: None
Allergies: PCN

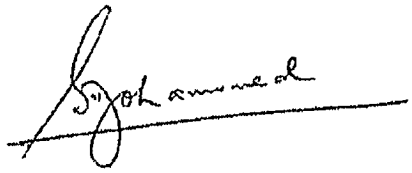
PMH: GERD
PSH: C-section 1989
SHx: No Drugs; No Smoking; No drinking
PFH: CVA; Diabetes mellitus: Mother, father; HTN: Mother; Mother

Exam:
Vitals: WEIGHT 146.8 |BP 150/70 |RESP 16 |PULSE 80 |NOTES DBC
General: Patient is alert, awake, and in no distress.
HEENT: Throat was normal, TMs normal, no lymphadenopathy, no thick nasal discharge.
Chest: Clear to auscultation, no crackles, wheezing, or rales were noted.
Heart: Regular rate and rhythm, no murmurs or extra sounds noted. No JVD
Abdomen: No tenderness, no masses, no organomegalies, no rebound tenderness, bowel sounds were normal.
Ext: No edema noted, positive pedal pulse. No skin changes, or ulcers noted.
BACK: Muscle spasms noted along spine.

Assessment:
1) Back strain secondary to MVA

Plan: continue present treatment.
Safety education discussed with patient.
I explained to the patient the side effects, complications and what to expect from the medicines.
Patient councelled regarding compliance to treatment and regular follow ups.

DOS:05/17/2010



Mohammed Syed, M.D.
Digitally Signed
Charted: 05/17/2010

22-B14-543

Mundy Pain Clinic P.C.
6240 Rashelle Drive, Suite 103
Flint, MI 48507
Phone: 810-232-9800
Fax: 810-232-7710

INITIAL EVALUATION

Patient ID: 3080
Patient Name:
Date of Birth:
Date of Injury: 04/23/2010
Date of Initial Evaluation: 05/20/2010

CHIEF COMPLAINT: MVA.

HISTORY OF PRESENT ILLNESS: This is a 49-year-old African-American female driver that was involved in a motor vehicle collision. She was rear ended at an unknown rate of speed but it was fast according to the patient while she was stopped at a red light. She was wearing a seatbelt. The airbags were not deployed though the vehicle was equipped. She did obtain a police report. EMS did not show up and nor did not go to the hospital. She states that she was shaken up by the accident quite a bit; however, her emotional state surpassed that of her physical complaint, so she opted to go home instead. When she woke up the next morning, she found herself to be in pain. Cervical pain was a 7/10 in quality and sharp quality, bilateral radiation with paresthesias upto the fingertips were noted. The thoracic spine was 7/10 and radiating to the right towards her chest around the flank. Her lumbar spine is worse, this is 10/10, sharp and bilateral radiation to the back of her knees. Additionally, the patient has had posttraumatic headaches approximately four episodes a week lasting one to two hours. These resolved only with excess use of over-the-counter medication for headaches. .

REVIEW OF SYSTEMS: As per HPI.

MEDICATIONS: None.

ALLERGIES: Penicillin which gives her hives.

PRIOR INJURIES OR ACCIDENTS: None.

PRIOR SURGICAL PROCEDURES: She had a cesarean section x1.

PRIOR HOSPITALIZATIONS: None.

FAMILY HISTORY: Noncontributory.

SOCIAL HISTORY: She is married. Denies alcohol. Denies tobacco use. She works as a nursing home aide.

LAST DATE WORKED: Presently working.

EDUCATION: High school completion.

22-B141-543

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Flint, MI 48507
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Fax: 810-232-7710

Patient ID: 3080
Patient Name:
Date of Birth:
Date of Injury: 04/23/2010
Date of Initial Evaluation: 05/20/2010

PHYSICAL EXAMINATION: Vitals: She had a blood pressure of 136/84, pulse 72, and respirations 15. She is 5 feet 10 inches and weighs 149 pounds. General: Well nourished and developed, in no acute distress, alert and oriented x4. HEENT: Head is normocephalic and atraumatic. Pupils are equally round and reactive to light and accommodation. Extraocular muscles are intact. Cardiovascular: S1, S2. No murmurs, rubs, or gallops. Pulmonary: Clear to auscultation bilaterally. No wheezing, rales, or rhonchi. Abdomen: Soft, nontender, and nondistended. Bowel sounds x4, normoactive. Extremities: Full range of motion. No clubbing, cyanosis, or edema. Neurological Examination: Cervical spine palpation on the vertebral aspects of spinous processes and transverse processes revealed paraspinal musculature tenderness of a mild-to-moderate nature as well as spinous processes tenderness from C3 to C7 diffusely. Spurling's test was performed and it was positive bilateral up to the fingers with paresthesias. Rotation, flexion, extension of the cervical spine was reduced to approximately 40%. Sensation slightly decreased. Vibration intact. Thoracic spine examination was within normal limits. Lumbar spine examination, palpatory findings were that of moderate to severe paraspinal muscle spasm with tissue texture abnormality, asymmetry, restriction of motion, and tenderness to palpation along the spinous processes of L3, L4, and L5. Flexion and extension of lumbar spine was reduced to approximately 25%. Straight leg test was performed and was positive bilateral 30 and 35 degrees respectively, left and right. Muscle strength 5/5. Deep tendon reflexes 2/4. Gait was stable.

DIAGNOSES:
1. Cervical strain, rule out radiculopathy.
2. Thoracic strain, rule out radiculopathy.
3. Lumbar strain, rule out radiculopathy.
4. Posttraumatic headaches.

22--B141-543

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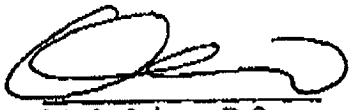
Patient ID: 3080
Patient Name:
Date of Birth:
Date of Injury: 04/23/2010
Date of Initial Evaluation: 05/20/2010

RECOMMENDATIONS:

1. Physical therapy and occupational therapy three sessions a week x4 weeks.
2. Pharmacotherapy with Valium 10 mg one p.o. t.i.d. #60 dispensed and pain medication with Lortab 7.5/500 mg one p.o. t.i.d. #90 dispensed. Additionally, the patient is to wear a lumbar brace which has been prescribed to her at this time and reevaluation to take place in 30 days. Physical therapy goals to restore motor deficits, increase range of motion, and reduction of pain.



Martin Quiroga, D.O.

Transcribed by JJ Medical Systems
DD: 08/05/10
DT: 08/06/10
PTV/WF/MW

3080

Mundy Pain Clinic P.C.
6240 Rashelle Drive, Suite 103
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PHYSICAL THERAPY SCRIPT

Patient's Name: _____ Date: 5-20-10

Diagnosis : 1. _____

Diagnosis: 2. _____

Diagnosis: 3. _____

Diagnosis: 4. _____

Evaluate and Treat X Area C-T-L Spine

Evaluate and Treat X Area Post Traum H.A

Evaluate and Treat X Area _____

Evaluate and Treat _____ Area _____

Frequency: 3/wk Duration: 4 wks Onset Date: 4-23-10

Precautions: _____

Physician's Name: Dr. Quiroga

Physician's Signature: _____ Date: 5-20-10